DEPARTMENT OF SOCIAL AND HEALTH SERVICES
MEDICAL ASSISTANCE ADMINISTRATION
Olympia, Washington

To: Physical Therapists
Managed Care Plans
CSO Administrators
Regional Administrators

Memorandum No: 03-45 MAA
Issued: June 30, 2003

For Information Call:
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From: Douglas Porter, Assistant Secretary
Medical Assistance Administration (MAA)

Supersedes: 02-43 MAA

Subject: Physical Therapy Program: Fee Schedule Changes

Effective for dates of service on and after July 1, 2003, the Medical Assistance Administration (MAA) will implement:

- The updated Medicare Physician Fee Schedule Data Base (MPFSDB) Year 2003 relative value units (RVUs);
- The Year 2003 additions of Current Procedural Terminology (CPT™) codes; and
- Changes to Health Care Financing Administration Common Procedure Coding System (HCPCS) Level II codes.

Maximum Allowable Fees

MAA is updating the fee schedule with Year 2003 RVUs. The 2003 Washington State Legislature **has not appropriated a vendor rate increase** for the 2004 state fiscal year. The maximum allowable fees have been adjusted to reflect the changes listed above.

Coding Changes

The Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standardized set of procedure codes. MAA is discontinuing all state-unique procedure codes and modifiers and will require the use of applicable CPT and HCPCS procedure codes. MAA is currently upgrading its claims processing system, and state-unique procedure codes used in the Physical Therapy Program will be discontinued by October 2003. MAA will notify providers of all coding changes in a later memorandum.

Attached are updated replacement pages 13-16 for MAA's Physical Therapy Program Billing Instructions, dated May 2000. To obtain DSHS/HRSA provider numbered memoranda and billing instruction, go to the DSHS/HRSA website at http://hrsa.dshs.wa.gov (click ***the Billing Instructions and Numbered Memorandum*** link). These may be downloaded and printed.

Bill MAA your usual and customary charge.

Fee Schedule

Note: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes.

Due to its licensing agreement with the American Medical Association, MAA publishes only official, brief CPT code descriptions. To view the full descriptions, please refer to your current CPT book.

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
Tens Application			
64550	Apply neurostimulator	$17.06	$5.46
Muscle Testing (The maximum allowable is for payment in full, regardless of time required.)			
95831	Limb muscle testing, manual	18.65	9.55
95832	Muscle testing manual	17.06	9.55
95833	Body muscle testing, manual	24.80	16.15
95834	Body muscle testing, manual	27.30	20.25
95851	Range of motion measurements	16.84	5.69
95852	Range of motion measurements	13.42	3.87
Modalities			
97010	Hot or cold packs therapy	Bundled	
97012	Mechanical traction therapy	9.10	9.10
97014	Electrical stimulation therapy	8.64	8.64
97016	Vasopneumatic device therapy	8.64	8.64

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97018	Paraffin bath therapy	$4.10	$4.10
97020	Microwave therapy	2.96	2.96
97022	Whirlpool therapy	9.10	9.10
97024	Diathermy treatment	2.96	2.96
97026	Infrared therapy	2.96	2.96
97028	Ultraviolet therapy	3.64	3.64
(For the procedures listed below, the therapy provider is required to be in constant attendance.)			
97032	Electrical stimulation	10.01	10.01
97033	Electrical current therapy	12.51	12.51
97034	Contrast bath therapy	8.65	8.65
97035	Ultrasound therapy	7.51	7.51
97036	Hydrotherapy	14.11	14.11
97039	Physical therapy treatment	7.28	7.28
Therapeutic Procedures (Therapy provider is required to be in constant attendance.)			
97110	Therapeutic exercises	17.06	17.06
97112	Neuromuscular re-education	17.52	17.52
97113	Aquatic therapy/exercises	18.20	18.20
97116	Gait training therapy	15.02	15.02
97124	Massage therapy	13.65	13.65
97139	Physical medicine procedure	9.78	9.78
97140	Manual therapy	16.15	16.15
97150	Group therapeutic procedures	11.38	11.38

Procedure Code	Brief Description	July 1, 2003 Maximum Allowable Fee	
		Non Facility Setting	Facility Setting
97504	Orthotic training	$17.29	$17.29
97520	Prosthetic training	16.84	16.84
97530	Therapeutic activities	17.29	17.29
97535	Self care mngment training	18.65	18.65
97537	Community/work reintegration	16.61	16.61
97542	Wheelchair mngment training	Not Covered	
97545	Work hardening	Not Covered	
97546	Work hardening add-on	Not Covered	
97601	Wound care selective	24.12	24.12
97602	Wound care non-selective	19.11	10.01
Tests and Measurements			
97001	Pt evaluation	44.82	38.45
97002	Pt re-evaluation	24.12	19.34
97703	Prosthetic checkout	13.65	13.65
97005	Athletic evaluation	Not Covered	
97006	Athletic re-evaluation	Not Covered	
97750	Physical performance test	17.52	17.52
Other Procedures			
0002M*	Custom splint (cockup and/or dynamic supply)	47.76	
97532	Cognitive skills development	Not Covered	
97533	Sensory integration	Not Covered	
97799	Unlisted physical medicine rehabilitation service or procedure	By Report	

*State-unique code

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- The provider must submit claims as described in MAA's billing instructions.

- MAA requires providers to obtain an ICN for an initial claim within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

- MAA may grant exceptions to the 365 day time limit for initial claims when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

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[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider MUST refund any payment(s) received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider MAY refund payment made by the client and then bill MAA for the service.